BEFORE THE PERSONNEL APPEALS BOARD

STATE OF WASHINGTON

JAMIE NELSON, Appellant, v. DEPARTMENT OF SOCIAL AND HEALTH SERVICES, Respondent.	Case No. DEMO-97-0010 FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER OF THE BOARD

I. INTRODUCTION

1.1 **Hearing.** This appeal came on for hearing before the Personnel Appeals Board, WALTER T. HUBBARD, Chair, and GERALD L. MORGEN, Vice Chair. The hearing was held on January 13, 2000, in the Administrative Conference Room at Fircrest School in Seattle, Washington.

1.2 **Appearances.** Appellant Jamie Nelson was present and was represented by Lori Hansen, Attorney at Law. Respondent Department of Social and Health Services was represented by Paige Dietrich, Assistant Attorney General.

1.3 **Nature of Appeal.** This is an appeal from the disciplinary sanction of a demotion for neglect of duty, gross misconduct and willful violation of published employing agency or department of personnel rules or regulations. Respondent alleges that Appellant failed to administer the proper dose of medication to a patient, failed to properly document the medication she did administer, and failed to follow the correct procedural steps to ensure that the proper dose of medication was administered.

1.4 **Citations Discussed.** WAC 358-30-170; Baker v. Dep't of Corrections, PAB No. D82-084 (1983); McCurdy v. Dep't of Social & Health Services, PAB No. D86-119 (1987); Rainwater v.

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School for the Deaf, PAB No. D89-004 (1989); Skaalheim v. Dep't of Social & Health Services, PAB No. D93-053 (1994); Aquino v. University of Washington, PAB No. D93-163 (1995).

II. FINDINGS OF FACT

2.1 Appellant Jamie Nelson was a Licensed Practical Nurse (LPN) 2 and a permanent employee of Respondent Department of Social and Health Services (DSHS) at Fircrest School. Appellant and Respondent are subject to Chapters 41.06 and 41.64 RCW and the rules promulgated thereunder, Titles 356 and 358 WAC. Appellant filed a timely appeal of her demotion April 3, 1997.

2.2 Appellant had been employed at Fircrest School for approximately 5½ years. She was provided training and was aware of the agency's policies and procedures. She had a history of informal disciplinary actions which included a letter of reprimand and a counseling memo for making medication errors. In addition, Appellant's performance evaluations establish that she had a history of making errors related to administering and documenting medications.

2.3 By letter dated February 8, 1997, Dr. Asha Singh, Superintendent of Fircrest School, informed Appellant of her demotion from LPN 2 to LPN 1, effective March 7, 1997. Dr. Singh alleged that on August 22, 1996, Appellant failed to administer the prescribed dose of Depakote to client Mike but then signed the Medication Administration Record (MAR) to indicate that she had administered the correct dose.

2.4 Fircrest clients are medically fragile and administration of the appropriate medications for the clients is taken very seriously. Mike had a severe seizure disorder. His disorder was very difficult to control and proper administration and monitoring of his medication was crucial to his well-being.

2.5 At the time of this incident, Appellant was responsible for administering and documenting medications given to the clients on unit 233 during the evening shift. Mike was a client on unit 233.

He was prescribed 1750 milligrams of Depakote to be given at 8 a.m., 4 p.m., and 8 p.m. During the evening of August 22, 1996, Appellant was responsible for administering Mike's 4 p.m. and 8 p.m. medications.

2.6 Mike's Depakote was contained in sealed "BINGO" cards. One card contained 500 milligram tablets and one card contained 250 milligram tablets. During each medication period, Mike was to be given three 500 milligram tablets and one 250 milligram tablet.

2.7 Jean Dashtestani was an LPN 2 on the day shift in unit 233. When she reported to work on August 23, 1996, she proceeded to administer Mike's 8 a.m. medications. She discovered that during the previous evening shift, a total of five 500 milligram Depakote tablets and two 250 milligram Depakote tablets had been removed from Mike's BINGO card. If Mike had been given his full dose of Depakote, six 500 milligram Depakote tablets and two 250 milligram Depakote tablets would have been removed.

2.8 Ms. Dashtestani also checked Mike's Medication Administration Record (MAR). She discovered that Appellant indicated by initialing the MAR that Mike had been given full doses of Depakote. Ms. Dashtestani determined that a medication error had occurred and reported her concern to Registered Nurse (RN) 4 Helen Finch.

2.9 Ms. Finch and Ms. Dashtestani reviewed Mike's BINGO cards and MAR and reviewed the cards for other clients to determine whether a miscount had occurred or whether there was some other explanation for the error. They found no other errors or irregularities in client medications. As a result, Ms. Finch initiated an Incident Report and Ms. Finch and Ms. Dashtestani initiated a Personnel Conduct Report (PCR) against Appellant.

2.10 Ms. Finch investigated the PCR and completed the Supervisor's Report. She forwarded the PCR to Lars Watson, Developmental Disabilities Administrator (DDA) 2. Mr. Watson conducted

the administrative-level hearing. After considering all the investigative information and the comments provided by Appellant, Mr. Watson determined that Appellant failed to administer the prescribed does of medication to Mike at either 4 p.m. or 8 p.m. Mr. Watson forwarded the information to Dr. Asha Singh.

2.11 Dr. Singh is the appointing authority for Fircrest School. She reviewed all the materials, including Appellant's personnel history, and concluded that misconduct had occurred. Dr. Singh concluded that Appellant failed to provide Mike with the appropriate dose of medication which put Mike at risk of having a seizure. Dr. Singh also concluded that Appellant incorrectly completed the MAR. In determining what level of discipline to impose, Dr. Singh considered the seriousness of the incident, the potential impact on Mike, Appellant's history of documented medication errors, Appellant's performance evaluations and Appellant's history of counseling and reprimands. Dr. Singh concluded that demotion to a position where Appellant would be under close supervision when she was providing treatment and medication to clients was appropriate.

2.12 Mike did not appear to suffer any ill effects from Appellant's failure to administer him the proper dose of Depakote.

2.13 Fircrest School Procedure I.A.01 defines neglect of clients, in part, as "the failure to provide treatment . . . to a resident which is necessary to maintain or improve that resident's health or safety, and the failure to provide that treatment . . . results in . . . potential jeopardy to the health, safety or welfare of the resident . . . ." Examples of neglect include the failure to carry out physician's orders for distribution of medications.

2.14 Fircrest School Nursing Procedure F.5 addresses, in part, the prompt and safe administration of medications and provides the procedure to be followed when medications are administered. The procedure for administering medications includes safeguards for ensuring that medications are

removed from the BINGO cards and that all the medications administered to clients are recorded on the appropriate MAR. In addition, the procedures require that when medication is not administered, a notation is made in the Health Care Notes and on the appropriate MAR.

III. ARGUMENTS OF THE PARTIES

3.1 Respondent argues that Appellant neglected her duty to administer medication properly which put Mike's health and the agency at risk. Although Mike did not appear to suffer any ill effects as a result of Appellant's error, Respondent argues that the potential existed for him to suffer ill effects. Respondent further argues that Appellant was familiar with agency procedures, yet she failed to abide by those procedures when she failed to administer the appropriate dose of medication to Mike and when she failed to properly document the medication he was given. Respondent asserts that the agency should not have to wait until a client suffers ill effects from an employee's actions before taking discipline and that based on Appellant's ongoing history of making medication errors, demotion is the appropriate disciplinary sanction.

3.2 Appellant provided no testimony or evidence to dispute the allegations in the disciplinary letter. However, she argues that Respondent failed to prove that she did not administer the appropriate medication to Mike or that she violated agency procedures. She further argues that Respondent failed to thoroughly review her personnel history and consider her career before disciplinary action was taken. Appellant asserts that the disciplinary action was taken in retaliation for a discrimination complaint she filed against the agency.

IV. CONCLUSIONS OF LAW

4.1 The Personnel Appeals Board has jurisdiction over the parties hereto and the subject matter herein.

4.2 In a hearing on appeal from a disciplinary action, Respondent has the burden of supporting the charges upon which the action was initiated by proving by a preponderance of the credible evidence that Appellant committed the offenses set forth in the disciplinary letter and that the sanction was appropriate under the facts and circumstances. WAC 358-30-170; Baker v. Dep't of Corrections, PAB No. D82-084 (1983).

4.3 Neglect of duty is established when it is shown that an employee has a duty to his or her employer and that he or she failed to act in a manner consistent with that duty. McCurdy v. Dep't of Social & Health Services, PAB No. D86-119 (1987).

4.4 Gross misconduct is flagrant misbehavior which adversely affects the agency's ability to carry out its functions. Rainwater v. School for the Deaf, PAB No. D89-004 (1989).

4.5 Willful violation of published employing agency or institution or Personnel Resources Board rules or regulations is established by facts showing the existence and publication of the rules or regulations, Appellant's knowledge of the rules or regulations, and failure to comply with the rules or regulations. A willful violation presumes a deliberate act. Skaalheim v. Dep't of Social & Health Services, PAB No. D93-053 (1994).

4.6 Although it is not appropriate to initiate discipline based on prior formal and informal disciplinary actions, including letters of reprimand, it is appropriate to consider them regarding the level of the sanction which should be imposed here. Aquino v. University of Washington, PAB No. D93-163 (1995).

4.7 Respondent has proven that Appellant neglected her duty and that her actions were contrary to published procedures. Appellant failed to administer the proper dose of medication to Mike, failed to correctly chart the medication she did give him, and failed to follow procedures that were in place to ensure that clients are given the correct medication. Appellant's misconduct interfered

with the agency's ability to ensure that clients receive quality care and rises to the level of gross misconduct.

4.8 As an LPN, Appellant was responsible for protecting clients from unsafe practices and neglect. However, Appellant disregarded this responsibility. Furthermore, she had a history of similar disregard for her responsibilities. Appellant must be held accountable for her actions. In this case, Dr. Singh demoted Appellant to an LPN position where she would be given direct supervision when administering medications. After considering the seriousness of this incident, the potential harm to the client, and Appellant's ongoing history of making similar errors, we conclude that the sanction of demotion is appropriate and the appeal should be denied.

V. ORDER

NOW, THEREFORE, IT IS HEREBY ORDERED that the appeal of Jamie Nelson is denied.

DATED this _____ day of _____, 2000.

WASHINGTON STATE PERSONNEL APPEALS BOARD

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Walter T. Hubbard, Chair

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Gerald L. Morgen, Vice Chair